BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

CORNELIA E. FRISTO	)	
Claimant	)	
VS.	)	
	)	Docket No. 195,567
J.C. PENNEY'S	)	
Respondent	)	
Self-Insured	)	
	)	

ORDER

Respondent appealed the March 11, 2004 Award entered by Administrative Law Judge (ALJ) Steven J. Howard. The Appeals Board (Board) heard oral argument on September 14, 2004.

APPEARANCES

James R. Shetlar of Overland Park, Kansas, appeared for claimant. Kip A. Kubin of Kansas City, Missouri, appeared for respondent.

RECORD AND STIPULATIONS

The record considered by the Board and the parties' stipulation are listed in the Award, including the court-ordered independent medical examination report issued by James S. Zarr, M.D., dated August 18, 1998.

Issues

Claimant injured her low back and neck on March 2, 1994, when she fell at work. In the March 11, 2004 Award, Judge Howard determined claimant suffered a ten (10) percent impairment of function. Beginning December 2, 1994, when claimant's wages were reduced because of a change of position with respondent Judge Howard determined claimant was entitled to a work disability since claimant was no longer earning 90 percent of the average weekly wage she was earning at the time of her accident. The ALJ awarded permanent partial disability compensation for a 43.74 percent work disability

based upon the average of a 66.67 percent task loss and a wage loss of 21.8 percent.[1] Thereafter, respondent could no longer accommodate her restrictions, and claimant was terminated. Judge Howard found that claimant failed to make a good faith effort to find appropriate employment after she left work with respondent and, therefore, a wage earning capacity of $280 per week was imputed, which resulted in a wage loss of 60.5 percent. Beginning April 19, 1996, Judge Howard determined claimant was entitled to a 63.59 percent work disability based on the average of her 66.67 percent task loss and her 60.5 percent wage loss.[2] The ALJ Awarded disability compensation totaling $86,422.26.

Respondent appeals and seeks review of the ALJ's findings concerning the nature and extent of claimant's disability. Respondent contends that claimant failed to prove her entitlement to a work disability because not all of claimant's restrictions are medically related to her March 2, 1994 injury at work. Claimant also suffered a work-related injury on February 9, 1994. That injury was to claimant's left arm and is the subject of a separate docketed claim. Respondent also argues that because the record fails to establish which restrictions were for which injury and, accordingly, which injury resulted in claimant's termination, claimant has failed to prove that her loss of employment was due to the restrictions imposed for the March 2, 1994 back injury.

Respondent also alleges Judge Howard erred by considering the restrictions of Dr. Zarr because the doctor did not testify.

Conversely, claimant argues that the opinions of Dr. Bieri are the most credible as to diagnosis, restrictions, percentage of functional impairment and task loss but otherwise the ALJ's Award should be affirmed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

After reviewing the entire record and considering the parties' argument, the Board finds and concludes:

Claimant worked for respondent nineteen (19) years. She worked in the warehouse as a package checker, checking packages and carrying boxes to different areas and checking merchandise in bins. Claimant began noticing problems in her arms in November 1993. Claimant would occasionally go to the nurses' station to get a cold pack, but not often as she had to have written permission. Claimant did see her family physician, Larry

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[1] Using a 21.8 percent wage loss and the 66.67 percent task loss actually yields a 44.24 percent work disability not the 43.74 percent work disability awarded by the ALJ.

[2] Horace Smith testified at page 9 of his deposition, that claimant was placed on medical leave on April 9, 1996, but at page 13, he said claimant was put on unpaid leave of absence effective Jan. 5, 1996, and terminated effective April 10, 1997.

Harris, M.D., as respondent told her she could not go see a worker compensation doctor. Eventually, however, claimant was referred to Vito Carabetta, M.D., by respondent's nurse.

Dr. Carabetta initially treated claimant for injuries to her elbow and left shoulder. He also ordered physical therapy and anti-inflammatories for pain. Dr. Carabetta continued claimant on her usual work.

When claimant was seen again by Dr. Carabetta on March 15, 1994, claimant described to Dr. Carabetta a recent slip and fall on ice. Claimant believed the date to have been March 3, 1994. This fall caused neck and back pain and a worsening of her left shoulder. After the fall claimant's primary care physician started her on medications for the pain. Dr. Carabetta continued claimant in physical therapy for her elbow and shoulder for an additional two (2) weeks. At that time Dr. Carabetta imposed restrictions of maximum lifting to be limited to 25 pounds, due to claimant's back area problems and he scheduled claimant for an injection of the left elbow.

Claimant was seen again by Dr. Carabetta on March 23, 1994. Claimant said the injection had helped the elbow somewhat. Dr. Carabetta and claimant discussed her medication. Claimant still had complaints with regard to neck, mid and lower back pain. X-rays suggested only degenerative disk disease. Claimant was placed off work to rest for one week and physical therapy was once again ordered on a daily basis for one week followed by three times per week for an additional two weeks. Claimant was allowed to resume light duty work with a 25 pound lifting restriction.

Claimant saw Dr. Carabetta next on April 20, 1994. Claimant reported her neck was somewhat better but her low back pain had not improved whatsoever. Claimant reported her left elbow was doing better. As claimant's lower back was not improving, an MRI was ordered and claimant was continued in physical therapy. Dr. Carabetta continued claimant on the same restrictions.

Claimant was seen again on April 26, 1994. Dr. Carabetta noted claimant's cervical symptoms to be minimal and intermittent. The MRI showed a small disk herniation at the L5, S1 level, effacing the anterior subarachnoid space. Claimant's low back pain was unimproved and her arm symptoms were without change. Dr. Carabetta noted her examination did not show any specific difference. Again, claimant was started on a course of physical therapy to utilize ultrasound and traction. Claimant and Dr. Carabetta discussed her elevated blood sugar levels which needed to be controlled to ensure proper healing. Claimant's maximum lifting restriction was continued at 25 pounds.

Claimant was seen again by Dr. Carabetta on May 10, 1994. There was no improvement in claimant's back symptoms and reported she had an increase in pain in the last week prior to the visit and felt unable to work before the visit. Claimant noted an increase in radiating symptoms. Her left arm symptoms were stable and the shoulder was no longer problematic for her. She reported her elbow symptoms continued to be about

the same. Overall her examination did not show any specific difference. Dr. Carabetta recommended claimant see her primary care physician for to help her control her diabetes and an EMG test of the lumbar region and lower extremities was scheduled. Claimant was placed on bed rest for two (2) weeks and physical therapy was put on hold.

On May 23, 1994, claimant presented to Dr. Carabetta and reported she felt one-fourth better with bed rest. Blood sugar levels were discussed. Claimant stated the low back pain was constant and she had sciatic complaints bilaterally, more on the left side than on the right, without improvement. Claimant's electro-diagnostic studies were consistent with a mild lumbosacral radiculopathy. Claimant was scheduled for epidural steroid injections.

On June 2, 1994, Dr. Carabetta examined claimant for another followup visit. The epidural block had helped improve claimant's radiating symptoms. There was a limited amount of left lateral epicondyl tenderness. Claimant's left elbow symptoms remained the same. No problems with the shoulder area were noted and no left forearm spasm was found. Dr. Carabetta noted claimant appeared to have benefitted from the epidural injection.

On June 8, 1994, claimant was seen again by Dr. Carabetta. Claimant reported a flare-up in her symptoms with a second injection. Upon examination she did show an increase in lumbar spasm. Her flexibility had worsened. She had a positive left side straight leg raise sign and trace tenderness in the left lateral epicondyl was found. There was deterioration in claimant's lumbar complaints evident on examination. Claimant's left arm appeared stable. Her left elbow symptoms were without change. Dr. Carabetta believed claimant's condition warranted a surgical opinion and he referred her to Steve Hess, M.D., a neurogsurgeon.

Dr. Hess initially examined claimant on June 21, 1994, for her spine and intermittent leg numbness due to the fall claimant suffered in March 1994. Claimant described the pain as more of a cramp and numbing sensation in both legs. The symptoms were made worse by driving or sitting but can be relieved if claimant would stand or walk around. Claimant reported to Dr. Hess that conservative treatment in the way of physical therapy and epidural injections only relieved the symptoms temporarily. Dr. Hess noted claimant's motor strength was normal in her upper and lower extremities with direct testing but did state that claimant had mild hypersensitivity in the lateral foot and her great toe bilaterally. Claimant's MRI revealed she had a fairly large central disc protrusion at L5-S1 with what may be some mild foraminal stenosis associated with that. Dr. Hess' overall diagnosis was back pain with bilateral leg numbness sensations. As claimant did not have much success with conservative treatment Dr. Hess recommended further evaluation with a myelogram and CT scan.

On June 27, 1994, once again claimant was seen by Dr. Carabetta for a followup visit. He noted claimant had been seen by Dr. Hess on June 21, 1994. A myelogram was

scheduled for after the Fourth of July Holiday. Claimant's back symptoms were noted to be stable, however, the left upper extremity symptoms were variable. Claimant's examination was without change. At that point claimant was off work. She was told to follow-up with Dr. Hess after the myelogram and the medical treatment of her back condition was given to Dr. Hess.

Claimant was seen on July 21, 1994, for followup visit regarding her arm complaints with Dr. Carabetta. After reviewing the results of the myelogram, surgery was not seen as an option, despite the presence of a disk herniation. Claimant was on a progressive walking program at that point and she was off work secondary to her back problems. Claimant reported her back symptoms were starting to ease to some degree with her walking program. According to claimant her left elbow was getting worse. A second injection of the left lateral epicondyl was scheduled. It was believed claimant would return to work with regard to the left upper extremity, but would need to be off work for her back problems, per Dr. Hess.

On July 28, 1994, claimant presented to Dr. Hess for a follow-up visit after her tests were completed. Claimant's myelogram and CT scan were normal and neither tests revealed evidence of any root irritation or compression. However, claimant continued to complain of symptoms involving the paraspinal muscles in the lower thoracic and lumbar region extending into the gluteal area and the back of the thighs. Claimant did not have radiating radicular pain. Upon examination Dr. Hess noted tenderness in the aforementioned area and in the upper thoracic region. Claimant also described a decreased energy level at which point Dr. Hess believed claimant had more of a fibromyalgia symptomology than a radicular problem. He requested claimant be evaluated by Ken Huston, M.D., for another opinion.

Claimant was seen by Dr. Carabetta again on August 9, 1994. Claimant reported her elbow was better after an injection. Dr. Carabetta noted the elbow problem appeared to be improving and claimant's shoulder had not caused much difficulty. Dr. Carabetta felt claimant could work light duty with regard to her arm.

Claimant was referred to Dr. Huston who is a rheumatologist for an evaluation on August 12, 1994. However, Dr. Huston's records do not reflect an examination was conducted on claimant for fibromyalgia. Dr. Huston appears to have confined most of his diagnostic efforts to ruling out inflammatory or arthritic involvement. Claimant had a mild elevated SED rate but her blood profile was fine. No abnormality was noted on claimant's x-ray of her elbow taken September 21, 1994. Dr. Huston's general recommendation was to continue claimant on Elavil at bedtime and try Williams' flexion exercises.

Claimant saw Dr. Carabetta next on September 9, 1994 for her elbow problems. Her elbow had not shown any improvement and claimant believed it might be worse. She did exercises for her left elbow at home to strengthen the forearm muscle. Claimant described no subjective improvement in her left arm strength. Claimant was off work at this

time due to back problems. Upon examination Dr. Carabetta noted swelling at the left lateral epicondyl. There was a marked increase in claimant's symptoms with wrist extension. It appeared she was having considerable worsening with her elbow problems and Dr. Carabetta believed a referral to a surgical specialist was needed. Claimant's restrictions were kept the same. Claimant was then scheduled to see Dr. Toby on September 21, 1994.

Dr. Carabetta then referred claimant to E. Bruce Toby, M.D., who examined claimant for the first time on September 28, 1994. Dr. Carabetta referred claimant to Dr. Toby as she continued to have elbow problems that did not subside. Dr. Toby noted that claimant had been placed in a long arm cast for lateral epicondylitis a week before. Claimant complained of massive itching under the cast, however, once the cast was removed there was nothing remarkable seen on the skin area. Claimant also had complaints of stiffness but was able to move her elbow through a full range of motion but with discomfort and stiffness from the forearm in the lateral epicondyl area then up into her shoulder area. Dr. Toby did not have a an explanation for why claimant had complaints of stiffness after being in a cast for only one week nor for the diffusion of complaints into the shoulder area as well as her chronic back problems. Dr. Toby did not believe claimant to be a surgical candidate. Dr. Toby did recommend claimant have a home regimen to include instructions on her elbow range of motion in an effort to decrease some of the stiffness but had nothing else to offer her in the way of medical intervention. He believed claimant to have a chronic tennis elbow and recommended claimant to return on an as needed basis.

Claimant was seen again by Dr. Toby on October 12, 1994, for a follow-up visit due to the severe itching she was still having since her previous appointment. Claimant also continued to have complaints of back problems with spasms in her left arm. Claimant was tender over the lateral epicondyle and the medial epicondyl but to a lesser degree. Dr. Toby also noted claimant was tender on the right arm on the lateral side including over the lateral epidondyl. Claimant was given exercises to strengthen her right side as well as a recommendation to go to a pain clinic or an occupational medicine specialist. Dr. Toby believed claimant's back problems to be claimant's main priority.

Claimant was seen next by Dr. Carabetta on November 8, 1994. Claimant had been under Dr. Toby's care for her elbow problem. Apparently, claimant was felt to not be a surgical candidate at that time and she did not wish to pursue surgery. Claimant had been treated with a cast on her arm for a one (1) week period, but had some skin irritation. At that point, claimant was utilizing a forearm strap most of the day, but was not using a wrist splint. Claimant's elbow symptoms were constant and she reported the symptoms would increase in her left shoulder region after prolonged periods of inactivity. There was some irritation with this as she had returned to work 2-3 weeks prior. Claimant's low back pain was constant, without improvement but its intensity was variable. Claimant's lower extremity sciatic complaints were present without change. Claimant reported the traction, which had been tried previously, caused low back pain. Claimant was advised by Dr.

Carabetta to continue with her exercises and her forearm strap and to use a left wrist splint as needed. Claimant was to continue to work with restrictions at that point and was limited to a maximum lifting capacity of 15 pounds, no repetitive bending, stooping and no repetitive grasping with her left hand. Claimant was also prescribed medications.

Claimant was seen for final assessment on December 7, 1994. Dr. Carabetta and claimant discussed medications. Claimant reported working modified duty and using her elbow brace. Her elbow symptoms had not improved and she reported no change in her back complaints. There were no shoulder symptoms described. She continued using her home exercises daily, however, she noted some irritation with the exercises. Dr. Carabetta tested claimant's range of motion with regard to her left upper extremity and lower extremities. Dr. Carabetta believed all appropriate measures had been exhausted for claimant and he believed her to be at maximum medical improvement. She was continued on medications and the temporary restrictions were made permanent in order to avoid the chance of worsening her condition. Dr. Carabetta's final diagnosis was lumbosacral intervertebral disk herniation, of a limited degree and left lateral epicondylitis.

Dr. Carabetta rated claimant according to the *Guides*. He gave claimant a ten (10) percent impairment of the left upper limb as a result of her epicondylitis. He gave a seven (7) percent whole person impairment for the disc herniation in the lumbosacral region. For claimant's decrease in forward flexion, he allowed claimant a four (4) percent whole person impairment. And for her extension limitation in the lumbar spine he gave another three (3) percent whole person impairment. Claimant's functional impairment rating total, due to the lumbar problems, was fourteen (14) percent to the body as a whole. This rating is separate from the ten (10) percent impairment of the left upper extremity. Dr. Carabetta then imposed permanent restrictions of 15 pounds maximum lifting with no repetitive bending or stooping. For the left upper extremity he restricted claimant from any repetitive grasping activity with the left hand. Dr. Carabetta went on to say that claimant's fourteen (14) percent whole person impairment rating due to the lumbar area problem is attributable to her work-related fall in March of 1994 and the ten (10) percent impairment for the left upper extremity associated with her lateral epicondylitis is due to the original work injury.

Although Dr. Carabetta's final report is dated December 8, 1994, claimant did see Dr. Carabetta one final time in 1996. At that time claimant displayed symptoms of fibromyalgia. She did not show signs of fibromyalgia when Dr. Carabetta saw her on December 7, 1994. Dr. Carabetta did not believe claimant's fibromyalgia was work-related. However, Dr. Carabetta did testify that prior to rating claimant in 1994 he did receive reports from various doctors that examined claimant, particularly, Dr. Hess in July 28, 1994, that claimant showed signs of fibromyalgia. Dr. Carabetta believed the fibromyalgia pain syndrome may have started to develop at that point.

Claimant was seen next by K. Dean Reeves, M.D., on two occasions, November 1, 1995 and November 2, 1995. The November 1, 1995 visit was to obtain claimant's history and the second visit on November 2, 1995, was to perform an examination of claimant.

Claimant sought the medical opinion of Dr. Reeves through a friend that Dr. Reeves had been treating. Dr. Reeves recalled the first mention of pain-related problems occurred for claimant in the fall of 1993 while lifting totes as part of her work for respondent. The clothes containers weigh up to 40 pounds, lifting all day various amounts of weights. Claimant described the pain as beginning in her left shoulder, left arm and going down into her fingers. Claimant reported she was never in a "pain-free" state before the fall on ice in March of 1994. Claimant also described to Dr. Reeves changes in work occurring in 1994 with a job change still "light" but changed to a station which involved reaching out in front, pulling boxes to her and then bending over. With the amount of forward position of the right arm claimant noticed an increase of right arm pain. Claimant stated that she had difficulty walking up and down steps with increased pain and so she tried to modify her job to minimize walking the stairs.

At the November 2, 1995 examination, Dr. Reeves noted claimant's findings for diffusion of fibromyalgia and findings of trigger activity which would account for her symptoms. Dr. Reeves stated that the combination of symptoms that claimant has are those of both inadequacy of connective tissue and trigger point syndromes. Utilizing a pain model of impairment rating based on the *Guides*[3] Dr. Reeves rated claimant as having 30 percent for her functional impairment to the whole body. The only form of therapy Dr. Reeves recommended for light work was prolotherapy. He believed this was the only treatment modality that would address the connective tissue symptoms. He noted that once the fibromyalgia has proceeded to the degree claimant's has it is difficult to treat and slow to respond to treatment.

Claimant testified that after she was released from Dr. Carabetta she continued to work for respondent until January 12, 1996,[4] when respondent could no longer accommodate her work restrictions. Claimant has not pursued looking for employment since that date. Claimant testified after she was released from Dr. Carabetta she continued to work for respondent but respondent failed to keep her in jobs that fell within her restrictions.

Horace Smith, human resource manager for respondent, testified that initially respondent tried to accommodate claimant's work restrictions. Beginning December 2, 1994, she was placed in a different job and her pay was reduced from $13.43 an hour to $10.63, a twenty-one (21) percent reduction. She subsequently experienced some other problems and respondent placed her out on medical leave, for twelve (12) months. During this twelve (12) month period apparently respondent can try and place claimant in another position within the company that would fall within her restrictions. Mr. Smith testified that the twelve (12) months elapsed and respondent could not find a position for claimant.

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[3] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.).

[4] R.H. Trans. at 9 and 10 (Aug. 12, 2003).

Therefore, they separated claimant from employment as they could no longer accommodate her work restrictions.

At the February 27, 1996 preliminary hearing claimant testified that she has pain in her lower back, arms, neck and legs. She continues to have sleeping problems and constantly has muscle spasms which has lead to emotional problems and depression. The preliminary hearing held on February 27, 1996, was for both of claimant's work-related accidents. But at the request of respondent the ALJ ordered the two (2) claims separated for trial and award. Despite claimant's repeated requests to consolidate Docket No. 195,567, and Docket No. 196, 431 for trial, those requests were denied. Nevertheless, the first paragraph under Findings of Fact in the ALJ's Award in this docketed claim provides "[t]he findings set forth in Docket Number 196,431 are herein incorporated by references as if fully set out herein."[5] Due to the ALJ's denial of claimant's request to consolidate, separate evidentiary depositions were taken in the two (2) cases. As the Award in Docket No. 196,431, was based upon a different record, it would be inappropriate in this case to adopt the findings made in the award for claimant's other docketed claim.

Claimant underwent an independent medical examination by Arnold L. Katz, M.D., on August 27, 1998. Dr. Katz, who is board-certified in internal medicine and rheumatology, did not believe claimant had fibromyalgia. Furthermore, Dr. Katz could not attribute any of claimant's symptoms or complaints to a work-related injury with a reasonable degree of certainty.

Claimant was examined by Peter Bieri, M.D., on November 6, 2000, at her attorney's request. Dr. Bieri is board-certified as an independent medical examiner. Dr. Bieri obtained claimant's history, reviewed x-rays and performed an examination. Dr. Bieri opined that according to the *Guides*[6] claimant had a seven (7) percent whole person impairment for specific disorder of the lumbar spine, a seven (7) percent whole person impairment for range of motion deficits of the lumbar spine and that the combined whole person impairment of the lumbar spine regions would be fourteen (14) percent. Dr. Bieri opined this was attributable to the injury claimant sustained on March 2, 1994. He also opined that claimant had a ten (10) percent left upper extremity for pain and weakness secondary to lateral epicondylitis which translates to a six (6) percent whole person impairment. Claimant's combined whole person impairment would be nineteen (19) percent. Dr. Bieri noted claimant demonstrates fibromyalgia as a diagnosis, but no edition of the *Guides* allows for a percentage of impairment on that basis. Dr. Bieri then imposed restrictions of occasional lifting to ten (10) pounds, with negligible frequent or constant lifting. Sedentary work involves sitting most of the time with occasional walking or standing for brief periods.

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[5] Award at 2 (March 11, 2004).

[6] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (3rd ed.).

At the motion hearing held June 26, 2001, claimant's counsel advised the court that Docket Number 195,567 pertains to claimant's low back and claimant's restrictions are addressed by Dr. Carabetta and also by Dr. Zarr, one of the court appointed independent medical examiners. Because Dr. Zarr was appointed in Docket Number 195,567, his report will be considered as part of the record in this case.[7]

James S. Zarr, M.D., evaluated claimant on August 18, 1998, for a court-ordered independent medical examination. Dr. Zarr interviewed claimant, took a history and performed a physical examination. Dr. Zarr's overall impression was fibromyalgia/myofascial diffuse pain. He believed claimant suffered some mild impairment from her work-related injury but noted that all of her findings were subjective. Dr. Zarr rated claimant as having a ten (10) percent whole body impairment based solely on her subjective complaints of pain and claimant's history taken at the time of her examination. He recommended she be restricted to light duty work with no lifting greater than twenty-five (25) pounds.

The Board notes that paragraph four (4) of the Findings of Fact in the ALJ's March 11, 2004 Award contains contradictory findings concerning the claimant's average weekly wage. In addition to a base wage of $537.20, Judge Howard notes that claimant was provided fringe benefits totaling $171.65. Accordingly, once the fringe benefits stopped, claimant's average weekly wage became $708.85. Paragraph four (4) states these fringe benefits were "in effect until April 19, 1996,"[8] but also finds in that same paragraph "the fringe benefits were discontinued 30 days subsequent to claimant[']s leaving employment [on] January 13, 1996. Accordingly, on February 14, 1996, claimant[']s wage was $708.85."[9] To further confuse the matter, neither of these two dates were used in the ALJ's Award calculation. Instead, the Award provides for a change in claimant's wage loss which is calculated upon the average weekly wage of $708.85, which includes the value of the fringe benefits, beginning January 13, 1996, the date claimant stopped working for respondent. On page 6 of the Award, Judge Howard again states that "[f]ringe benefits for the claimant ceased effective April 19, 1996."[10] And finds that claimant's 60.5 percent wage loss is effective as of April 19, 1996.

The Board finds that respondent discontinued payment of claimant's fringe benefits 30-days after she was placed on medical leave. Claimant was placed on medical leave and last worked for respondent on January 13, 1996. The Board therefore agrees with the ALJ's finding on page 3 of the Award that claimant's gross average weekly wage was

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[7] ALJ Order (July 17, 1998).

[8] *Id.* at 6.

[9] *Id.* at 7.

[10] *Id.* at 6.

$708.85 beginning February 14, 1996. Based upon an imputed wage of $280.00 per week, claimant's wage loss was 60.5 percent beginning February 14, 1996. For the one month period from the date she last worked for respondent until fringe benefits were terminated, claimant's wage loss was 48 percent based upon a gross average base wage of $537.20 (without fringe benefits) and an imputed average weekly wage of $280.

There are similar inconsistencies and confusion in the award concerning the ALJ's finding of claimant's permanent impairment of function. At page 3 of the Award the ALJ correctly states that "Vito J. Carabetta, MD, . . . testified that claimant suffers a 14% functional impairment due to her lumbar spine [injury]."[11] It is noted that Dr. Peter Bieri likewise "indicates that claimant suffers a 14% functional impairment based upon the AMA Guides 4th Edition due to her lumbar spine injury."[12] However, at page 5 of the Award the ALJ concludes that claimant "is entitled to only her functional impairment as determined by Dr. Carabetta, 10%."[13] The Award is then calculated based upon a ten (10) percent permanent partial disability for the period claimant continued to work for respondent and was earning at least 90 percent of her preinjury average weekly wage. The Board finds that claimant's functional impairment is 14 percent and that the award calculation should be modified accordingly.

Finally, the ALJ found claimant suffered a 66.67 percent task loss based upon the restrictions given by Dr. Carabetta. Dr. Carabetta, however, did not make a task loss opinion. Rather, vocational expert Michael Dreiling applied Dr. Carabetta's restrictions to the task list he compiled to come up with the task loss percentage utilized by the ALJ. This procedure violates the requirement in K.S.A. 44-510e(a) that requires task loss be "in the opinion of the physician." The only physician to testify concerning task loss was Dr. Bieri.

Dr. Bieri reviewed Mike Dreiling's list of claimant's job tasks and determined that based on claimant's restrictions for her low back that claimant could not perform eight (8) out of the nine (9) job tasks and therefore claimant had a 87 percent job task loss. However, Dr. Bieri testified that there were no additional tasks lost due to claimant's fibromyalgia.[14]

Claimant has testified that she is not looking for work. Therefore, she has not made a good faith effort to secure employment. Vocational expert Michael J. Dreiling was the only vocational expert to testify on claimant's post-accident ability to earn wages. He interviewed claimant on December 13, 2000. Mr. Dreiling determined that if claimant

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[11] *Id.* at 3.

[12] *Id.* at 4.

[13] *Id.* at 5.

[14] Bieri Depo. at 26.

stayed within her restrictions as it pertains to her low back that her wage earning capacity would be between minimum wage and eight (8) dollars per hour. The Board agrees with the ALJ's determination that claimant retains the capacity to earn seven (7) dollars an hour and $280 a week.

Respondent also contends claimant should be denied an award for work disability in excess of the percentage of functional impairment because claimant was terminated due to restrictions imposed for her arm injury, not for her back injury. But the record fails to support respondent's contention that claimant's wage loss was due to only her scheduled injury. The restrictions respondent received from claimant's health care providers before she was placed on medical leave, were for both her upper extremity and her low back injuries. The Board finds that claimant was placed on a medical leave of absence by respondent due either to the restrictions for the back alone or for the combined restrictions resulting from the combination of conditions, but not due to restrictions for the upper extremities alone. This does not preclude a work disability award. There is no requirement in the Workers Compensation Act that the employee leave work or otherwise suffer a diminution of earnings due solely to the work-related injury.[15] In this case, the record indicates that claimant ultimately lost her job with respondent due to the restrictions she received for her back injury.

WHEREFORE, it is the finding, decision, and order of the Appeals Board that the March 11, 2004 Award entered by Administrative Law Judge Steven J. Howard is modified as follows:

WHEREFORE, AN AWARD OF COMPENSATION IS HEREBY MADE IN ACCORDANCE WITH THE ABOVE FINDINGS IN FAVOR of the claimant, Cornelia E. Fristo, and against respondent, J.C. Penney's, for an accidental injury which occurred on March 2, 1994, and based upon an average weekly wage of $537.20 and a compensation rate of $313.00, for the period beginning March 2, 1994 claimant is entitled to 24.14 weeks of temporary total disability or $7,555.82 followed by 15.15 weeks of permanent partial disability compensation through December 2, 1994, based on a fourteen (14) percent functional impairment or $4,741.95.

For the period beginning December 2, 1994 through January 13, 1996, when claimant was terminated and based on an average weekly wage of $537.20 with a compensation rate of $313.00 claimant is entitled to 58.29 weeks of permanent partial disability for a fifty-five (55) percent work disability or $18,244.77.

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[15] *See e.g.*, *Cavender v. PIP Printing, Inc.*, 31 Kan. App. 2d 127, 61 P.3d 101 (2003); *Lee v. Boeing*, 21 Kan. App. 2d 365, 899 P.2d 516 (1995); *Edmond v. Raytheon Aircraft Company*, Case No. 233,720, 2003 WL 1918535 (Kan. WCAB March 31, 2003); Aff'd by the Kansas Court of Appeals in an unpublished opinion, No. 90,523, 86 P.3d1025 (Kansas Court of Appeals unpublished opinion, April 2, 2004).

For the period beginning January 14, 1996 through February 13, 1996, when claimant's fringe benefits ceased, and based on a compensation rate of $313.00, claimant is entitled to 4.43 weeks based on a 68.5 percent work disability or $1,386.59.

Beginning February 14, 1996, claimant is entitled to a 74.75 percent work disability paid at a compensation rate of $313.00 or $68,070.87 for a total award of $100,000, all of which is due and is ordered paid in one lump sum less amounts previously paid.

The Board adopts the remaining orders set forth in the Award to the extent they are not inconsistent with the above.

IT IS SO ORDERED.

Dated this ____ day of May, 2005.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: James R. Shetlar, Attorney for Claimant
Kip A. Kubin, Attorney for Respondent
Steven J. Howard, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director